State of California Department of Consumer Affairs

DENTAL BOARD OF CALIFORNIA
1432 HOWE AVENUE, SUITE 85, SACRAMENTO, CA 95825-3241
TELEPHONE: (916) 263-2300
FAX: (916) 263-2140

DECLARATION AND REQUEST FOR REPLACEMENT LICENSE

Request for Replacement of:

- ☐ Pocket License - $50.00
- ☐ Wall Certificate - $50.00
- ☐ Fingerprint Cards - $56.00

Reason for Request

- ☐ Lost ☐ Destroyed
- ☐ Stolen ☐ Original not Rec'd
- ☐ Other _____

FEES ARE NON-REFUNDABLE

FOR OFFICE USE ONLY

Date Rec'd _____ Amount _____
Receipt No. _____ R.C. No. _____
Date Issued _____ Date Mailed _____

Article 6, Section 1021 – California Code of Regulations

Please type or print

First Middle Last

Full Name:

Number & Street City State Zip

Address:

License No.

Month Day Year

Date Original License was Issued:

Name license was issued under (if different from above)

License Classification: **DDS**

Social Security Number (Required):

Telephone Number: ( )

State circumstances for request:

_____

_____

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I hereby certify under penalty of perjury under the laws of the State of California that the statements and information set forth above are correct; that I will immediately return the license or certificate to the Dental Board of California should said license or certificate be found, or I will report its location should it become known to me.

Signature Date